

The Journal of Insurance & Indemnity Law

A quarterly publication of the State Bar of Michigan's Insurance and Indemnity Law Section

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Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.

From the Chair



Jason J. Liss
Fabian, Sklar, King
& Liss

Annual Business Meeting

At our section's Annual Business Meeting, scheduled for **October 17, 2019** at the State Bar of Michigan Building at 306 Townsend Street in Lansing, I will have the honor of becoming the next Chairperson of the Insurance & Indemnity Law Section of the State Bar of Michigan. I would like to congratulate current officers **Nicole Wilinski** and **Lauretta Pominville** on becoming our next Chairperson Elect and Secretary, respectively. I would also like to congratulate our newest officer, **Rabih Hamawi**, who bravely threw his hat in the ring to become our next Treasurer. Finally, I want to thank **Gus Igwe** for the fantastic job he did as Chairperson this past year and for leaving me some rather large shoes to fill!

In addition to our officers, our council has 10 members, each serving two-year terms. The two-year terms for five of our council members expire this year and members present at the October 17th business meeting will have the opportunity to vote on a slate of candidates vying to fill these coveted seats for the two-year term ending 2021. It's not too late for members interested in becoming a council member to have their names placed on the ballot. Those who are interested should contact Hal Carroll at HOC@halocarrollesq.com by **October 11, 2019**.

We will also be voting to amend our bylaws with respect to the date on which our annual business meeting will occur. Currently, our bylaws require our annual business meeting to coincide with the State Bar's annual convention. However, this past year, the State Bar directed that the annual business meetings of the various sections will no longer occur in conjunction with that of the State Bar itself. Accordingly, the proposed amendment to our bylaws states simply that our section's annual business meeting will occur in the month of October. Since we are no longer assured a venue for any particular date, this proposal affords the flexibility that may be needed year-to-year for the planning of our annual business meeting. In accordance with our bylaws, our members received the following announcement via an eblast from the State Bar:

Pursuant to Article X, Section 1, of the Insurance and Indemnity Law Section's bylaws, please be advised that we will be voting on the following proposed amendment to our [bylaws](#) at the Insurance and Indemnity Law Section's [Annual Business Meeting](#) on October 17, 2019, beginning at 2:00 p.m. at the State Bar of Michigan, 306 Townsend St, Lansing:

ARTICLE VIII MEETINGS

Section 1. The Council shall meet not less than four times per calendar year, the dates of which shall be tentatively scheduled at the annual meeting. A majority of the members of the council shall constitute a quorum. A majority of those present and voting shall be sufficient to take action on any matter before the Council. Members may attend in person or by telephone.

Section 2. The annual meeting of the Section shall take place during and in the same venue as the annual meeting of the State Bar of Michigan the month of October. A quorum shall consist of 18 members of the Section. A majority of those present and voting shall be sufficient to take action on any matter before the Section.

Section 3. Special meetings of the Council or the Section may be called by the Chairperson.

While I expect this amendment to pass with unanimity, I do not wish to discourage any of the contrarians within our membership from attending the meeting and engaging us in a robust debate over the propriety of this amendment.

Annual Program

An educational program will immediately follow our business meeting. This program will focus on homeowners and commercial property insurance claims, and is imaginatively titled:

Properly Preparing, Presenting & Handling Homeowners and Commercial Property Insurance Claims Prior to Litigation—Duties, Obligations, and Best Practices

Property insurance claims have their own set of rules and how a claim is prepared, presented and handled can make the difference between that claim being successfully paid, denied or litigated. Our presenters will include **Ethan Gross**, CEO of **Globe Midwest / Adjusters International** and **Bill Butler**, president of **Butler & Associates Adjusting Company**. Globe Midwest / Adjusters International is a public adjusting firm working on behalf of insureds, while Butler & Associates Adjusting Company is an independent adjusting firm working on behalf of insurers. Mr. Gross and Mr. Butler will share their knowledge, experience and insights in handling claims

on behalf of their respective clients during the claims process.

For the practitioner who does not regularly handle these types of matters, this program is an opportunity to learn the do's and don'ts required to successfully navigate the minefield lurking for the unwary in both the insurance policy and the claims process. For the practitioner who regularly handles these types of claims, this program is an opportunity to pick the brains of two very experienced adjusters who have deep knowledge of and experience with the subject matter.

As if that wasn't enough, there will be an informal social gathering following the program at a nearby restaurant a short walk from the State Bar Building, where the evening's festivities and networking will continue.

The program is free, and I encourage members who are interested in the topic, the camaraderie or both to register early, as space is limited.

Scholarship

Several years ago, our Section established a scholarship contest to annually award \$5,000 to a law student whose article, written in response to the Section's call for submissions, is selected by our Scholarship Committee. This year's scholarship was awarded to **Kaitlan Gant**, a third-year law student at MSU College of Law, whose article *Disqualify the Qualified: Independent Medical Examinations in Michigan's No-Fault System* appears in this edition of the Journal. We have invited Ms. Gant to our annual meeting to personally accept her scholarship award and we are hopeful she will be able to attend.

With this past year's scholarship now behind us, the Scholarship Committee is formulating the topic for our next "Call for Submissions." Current council member **Renee Vanderhagen** deserves high praise for suggesting the following topic for the next scholarship submission:

The legal use of medical and recreational marijuana is gaining traction at the state level across the country. While marijuana remains illegal at the federal level, insurers are increasingly receiving requests to reimburse medical marijuana for workers compensation treatment.

Identify the conflicts that exist between the laws in Michigan and federal law with regard to the use of medicinal marijuana by employees, and their workers compensation claims seeking reimbursement for treatment that includes the use of medicinal marijuana.

What issues might workers compensation insurers face as a result of being required to reimburse for drug treatment that is illegal under federal law?

While I think this is a very interesting and challenging topic, I invite and encourage any member (or nonmember for that matter) who has a suggestion for another potential topic to forward it to me at jliss@fabiansklar.com. Don't be shy, if we don't use your topic this year, we very well may use it next year.

I will conclude by stating that I am looking forward to chairing a fun-filled year on the council as we work to fulfill our mission and grow our section. ■

Notice of Election

At the Annual Meeting, the members will elect officers and council members for the coming year.

Our practice is for officers to begin in the Treasurer position and move to the Secretary, Chairperson-Elect and Chairperson position in succeeding years.

Council members are chosen at large. As this issue of the *Journal* goes to press, we have 6 candidates for five open seats. The bylaws provide that

"Each member of the Council shall each year:

- (a) Provide an article for publication in the quarterly publication; or
- (b) Actively participate in a Section committee

Voting is by paper ballot. If you want to be a candidate, please contact Hal Carroll at HOC@HalOCarrollEsq.com.

Ballot For Election Of Officer And Council Members

Annual Meeting - October 17, 2019

OFFICERS - Officers are elected to one-year terms. The candidates are:

- Chairperson Jason J. Liss, *Fabian, Sklar King & Liss*
- Chairperson-Elect Nicole Wilinski, *Collins Einhorn, Farrell PC*
- Secretary..... Laretta Pominville, *McNish Group*
- Treasurer..... Rabih Hamawi, *Law Office of Rabih Hamawi, PC*

COUNCIL MEMBERS - Council members are elected to two-year terms.

There are five vacancies, for terms that end in 2021. The candidates are:

- _____ Nicholas Andrews
- _____ Ann-Marie Earls*
- _____ Bob June*
- _____ Douglas McCray
- _____ Dan Steel, Jr.
- _____ Milea Vislosky*

* Indicates incumbent



INSURANCE AND INDEMNITY
LAW SECTION

Annual Business Meeting
and Program with informal
nearby off-site social hour

October 17, 2019

2-3 p.m. Business Meeting
3-5 p.m. Program
Social Hour to follow Program

State Bar of Michigan
306 Townsend St, Lansing

The background of the entire page is a photograph of a modern building with a glass facade. The building is reflected in the windows, creating a complex pattern of light and shadow. The sky is a clear, bright blue.

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Questions? Contact
Jason J. Liss at
(248) 553-2000 or
jliss@fabiansklar.com

Editor's Notes



By Hal O. Carroll
www.HalOCarrollEsq.com

The *Journal* is now completing its twelfth year. The *Journal* is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. The *Journal*—like the Section itself—takes no position on any dispute between insurers and insureds. All opinions expressed in contributions to the *Journal* are those of the author. We welcome all articles of analysis, opinion, or advocacy for any position.

Copies of the *Journal* are mailed to all state circuit court and appellate court judges, all federal district court judges, and the judges of the Sixth Circuit who are from Michigan. Copies are also sent to those legislators who are attorneys.

Index coming soon. Because we now have completed 48 issues, it's time to set up an index of past articles for those who want to be able to refer to analyses of the many topics the *Journal* has covered over these twelve years. Our plan is to have it up and running by next January.

The *Journal* is published quarterly in January, April, July and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1 and September 1). Copy should be sent in editable format to the editor at HOC@HalOCarrollEsq.com. ■



Who Says I'm a Criminal? Marijuana Cultivation and the Criminal-Act Exclusion

By Chris Kozak, *Plews Shadley Racher & Braun*

Most commercial property insurance policies contain an exclusion for damage caused by criminal acts. The policy language varies, but one general version bars coverage for a loss caused by:

“any dishonest or criminal act by you, any of your partners, members, officers, managers, or employees (including leased employees), directors, trustees, authorized representatives or anyone to whom you entrust the property for any purpose.”

Many aspects of this exclusion are commonly litigated: What does “dishonest” mean? What is the scope of “entrust” in the final item of the list? And does the offending act have to fall within the scope of the “purpose” for which the property was entrusted?

But with the advent of the *Michigan Regulation and Taxation of Marihuana Act*,¹ (“the Act”) we face a new interpretive issue: What is a “criminal act?”

The Problem

The goal of the Act was to bring the commercial marijuana industry out of “the illicit market,” to regulate it, and to extract

the State's fair share of revenue from marijuana operations.² As many members of this Section (and others) have observed, this raises complicated commercial-law issues because marijuana is still a controlled substance under federal law.³

This article addresses one aspect of the insurance relationship that is likely to be litigated as Michigan implements the Act. Property insurance policies almost universally include some form of the criminal-act exclusion quoted above. And as much as one would hope that policyholders and their insurers would explicitly address marijuana use in their policies, experience shows that is not always the case.

It would not be surprising, then, for a marijuana grower—operating in full compliance with the Act—to find itself in a dispute with its insurer (or its commercial landlord's insurer) over property coverage. Marijuana growth requires a substantial amount of heat and moisture, which can cause serious property damage if an accident occurs on the premises. An insurer may deny coverage, finding that since marijuana growth is a crime under federal law, the criminal act exclusion applies. If the policy is governed by Michigan law, policyholders should be prepared to challenge these denials. Depending on the facts, a grower could have a strong chance of success in court.

Who Decides?

Last year, the U.S. Court of Appeals for the Sixth Circuit confronted a similar issue.⁴ That case involved a commercial tenant who the DEA caught growing marijuana on the premises. The landlord (KVG) evicted the tenant and sought coverage for the damage under its property policy. The insurer (Westfield) denied coverage, pointing to the criminal act exclusion.⁵ The landlord asserted that the tenant was protected by the Medical Marihuana Act in force at the time.⁶ This argument caused the Sixth Circuit to pause for a moment and observe:

Under different circumstances, KVG might have a strong federalism argument in favor of coverage. In diversity cases, we act as faithful agents of the state courts and the state legislature. See *Erie R.R. Co. v. Tompkins*, 304 U.S. 64, 78 (1938) (“There is no federal general common law. Congress has no power to declare substantive rules of common law applicable in a state And no clause in the Constitution purports to confer such a power upon the federal courts.”). Since the MMMA was passed by ballot initiative, we would exercise even more care, lest we (as unelected judges) tread directly on the will of the People of the State of Michigan, who cannot easily correct any error we commit. Exercising the Michigan courts’ common-law power to interpret public initiatives, we would hesitate before reading a Michigan insurance policy to bar coverage for a “criminal act” when Michigan law confers criminal and civil immunity for the conduct at issue. Mich. Comp. Laws § 333.26424(b) (declaring that a person lawfully cultivating medical marijuana shall not be “subject to arrest, prosecution, or penalty *in any manner*, or denied *any right or privilege*” under state law) (emphasis added).⁷

The Circuit ultimately didn’t grapple with this question because, under the circumstances, “no reasonable jury could find that KVG’s tenants complied with Michigan law.”⁸

But the question remains. The Act contains broad immunity language comparable to the MMMA statute quoted by the court.⁹ And the rationale provided by the Circuit illustrates that the Supremacy Clause does not apply in matters of private, commercial contract, or at least not in this instance. Congress, through the Controlled Substances Act, has no

It would not be surprising, then, for a marijuana grower—operating in full compliance with the Act—to find itself in a dispute with its insurer (or its commercial landlord’s insurer) over property coverage.

more power to declare what is legal or illegal under *Michigan* law than, say, Alabama or California does.¹⁰ Growing marijuana is certainly still a *federal* crime. But since insurance policies are governed by state contract principles, and since Congress has expressly declined to get involved in the bulk of insurance law,¹¹ looking to federal law does not answer the question for coverage purposes.

Instead, the question is whether “after reading the entire contract, its language reasonably can be understood in differing ways.”¹² If it can, the policy must be “construed against the insurer and in favor of the insured.”¹³ In the ordinary case, these exclusions *are* ambiguous and should be construed in favor of the insured.

Two Reasonable Interpretations

A person growing marijuana in compliance with the Act has not committed a criminal act under Michigan law.¹⁴ The statute could not be any clearer. The more difficult question is whether the exclusion refers to things criminal under state law, under federal law, under either, or under some other measure of criminality.

And herein lies the problem for the insurer. No one, by reading the text of the policy, has any idea what was meant. It certainly could refer to conduct that was criminal under any law in force at the time of the loss. But it also could refer to things that have not been affirmatively legalized by the jurisdiction in which the policyholder operates and the law under which the contract is to be interpreted. Reasonable minds can disagree on this point, which is the classic measure of ambiguity.

There is at least a reasonable argument that the exclusion is not triggered by conduct legalized by, and regulated under, state law. An ordinary policyholder reading such a vaguely worded exclusion would not think he or she was risking insurance coverage by growing marijuana in a way that would not bring the local police to her door. So far as the vast majority of Michigan law enforcement is concerned, compliant marijuana growth is not something they can, or should, pay any attention to. Since the exclusion could have either a broad or a narrow meaning, it is ambiguous and should be construed against the insurer.

The typical response to this reasoning is that “criminal act” must refer to any act illegal under either state or federal law, or else federal crooks will get insurance for things that Michigan law never thought to address. This overstates the point. There is a world of difference between failing to legislate on a subject and *affirmatively* legalizing something.

For the skeptical insurer (or judge) it may help to point to the purpose of the exclusion. Illicit commercial activities are more risky to insure because they are unpredictable, usually associated with organized crime, and are not amenable to the ordinary risk controls implemented by legal businesses. Put

simply, an unlawful marijuana operation is much more likely to cause property damage than, say, a local nursery growing exotic plants legal to possess. Legalizing marijuana removes most of the unacceptable risks attendant to criminal business activity. By being compelled to cover property damage caused by a legal marijuana operation, an insurer is not being asked to accept a risk beyond that which it agreed to insure.

It is also worth pointing out that the insurer is the one who drafted the policy form. Property coverage is typically renewed annually and does not reach back into the past like third-party occurrence policies do. Insurers should be on notice of the recent changes in the law. If they sell property policies in Michigan without accounting for the presence of legal marijuana growing operations, the policyholder (who cannot negotiate these terms) should not be the one who suffers. Although the Michigan Supreme Court has barred the use of the “adhesion contract” doctrine to override *unambiguous* policy terms,¹⁵ it has not addressed the issue in the context of ambiguous terms.

If the policy is ambiguous, it is still a sound judicial practice to take into account the fact that the insurer drafts the policy terms and foists them on the customer. And since the “reasonableness” of the parties’ interpretations is the touchstone of the ambiguity analysis, it is also sound practice to consider the parties’ opportunity (or lack thereof) to draft the contract terms. In that context, it may be less reasonable for an insurer to claim the policy has one, self-serving interpretation, since the insurer had the means and opportunity to be more precise. It also may be more reasonable for a consumer to read the words “criminal act” and think his legal marijuana business is covered, as he had no input in the negotiation or definition of that term.

Conclusion

Insuring marijuana businesses is difficult, and Michigan law is still adapting to the new industry the voters created in 2018. This is only one small piece in the larger puzzle, but it is an important one. Insurers should be aware of the ambiguity in their current language, and policyholders should be aware that they may have coverage for these losses despite the federal Controlled Substances Act. ■

About the Author

Chris Kozak is an associate at Plews, Shadley, Racher & Braun, LLP. He represents policyholders in Indiana and Michigan in coverage disputes, particularly in high-stakes, high-value claims arising from sexual abuse and environmental contamination. His recent experience includes coverage work in response to the Larry Nassar and Harvey Weinstein abuse cases. He also works on complex environmental matters and statutory-interpretation issues. Before joining PSRB, Chris served as a law clerk on the

U.S. Court of Appeals for the Sixth Circuit and graduated from the Michigan State University College of Law. His email address is ckozak@psrb.com.

Endnotes

- 1 2018 I.L. § 1, MCL § 333.27951, *et seq.*
- 2 MCL 333.27952.
- 3 *See, e.g.*, 21 U.S.C. § 841(b)(1)(A)(vii).
- 4 *K.V.G. Props, Inc v Westfield Ins Co*, 900 F3d 818 (6th Cir 2018).
- 5 *Id.* at 820-22. Westfield had other defenses, but this was apparently the “lead” argument.
- 6 *Id.* at 821-22.
- 7 *Id.*
- 8 *Id.* at 822.
- 9 MCL 333.27960(1) (stating that when done in compliance with the Act, “the following acts are not unlawful, are not an offense, are not grounds for seizing or forfeiting property, are not grounds for arrest, prosecution, or penalty in any manner, are not grounds for search or inspection . . . and are not grounds to deny any other right or privilege.”), 333.27967 (“This act shall be broadly construed to accomplish its intent . . .”).
- 10 This principle was recently reaffirmed by the U.S. Supreme Court in *Murphy v Nat’l Coll Athletics Ass’n*, 138 S Ct 1461 (2018), where the Court struck down a federal law requiring states to prohibit sports betting.
- 11 15 U.S.C. § 1012(b).
- 12 *Fragner v Am Cmty Mut Ins Co*, 199 Mich App 537, 540 (1993). There has been some suggestion that *Klapp v United Ins Grp Agency, Inc*, 469 Mich 459, 469 (2003) requires a jury to examine extrinsic evidence before construing ambiguities in a policy against the insurer. *Id.* at 461; Hal O. Carroll, *Insurance and Indemnity 101: Resolving Ambiguities*, 12 MICH. J. INS. & INDEM. L. 1, 15 (Jan. 2019). But *Klapp* was not an insurance-policy case; it was a dispute over commissions in an insurance agent’s contract. *Klapp*, 469 Mich. at 449. Though *Klapp* and subsequent cases (including *Rory*, cited below) may have obliquely touched on insurance-policy interpretation, none of the Court’s cases squarely address when ambiguous insurance policies are construed against the drafter. The practical difficulties in following *Klapp* in an insurance-policy case are addressed elsewhere in this Journal. Carroll, 12 MICH. J. INS. & INDEM. L., No. 1, at 16-17. These difficulties are sufficiently vexing to cause this writer to assume the Court did not adopt such a rule *sub silentio*, and that the ordinary strict-construction rule remains in place.
- 13 *Id.*
- 14 MCL 333.27960(1).
- 15 *Rory v Cont’l Ins Co*, 473 Mich 457, 468-69 (2005).



Michigan Marijuana Liability – Seeing the Weed Through the Trees

By Eric P. Conn and Geoffrey A. Leskie, *Segal McCambridge Singer & Mahoney Ltd*

Michigan's new marijuana laws are dope, at least for those that understand the playing field. Given the recency of the changes, and the likely mainstream use of marijuana in the coming months and years, it is time for practitioners to re-hash the issues that are already starting to bud. However, it is also important to note that experience, whether it be in other similar areas of the law or after final implementation of the recreational marijuana statutes, will be the gateway to understanding this green landscape.

The Implementing Statute

In November 2018, voters in Michigan approved Proposal 1, which enacted the Michigan Regulation and Taxation of Marihuana Act ("the Act"). MCL 333.27951 et seq. Among other things, the Act was intended to make the use of marijuana legal for those 21 or older:

The purpose of this act is to make marihuana legal under state and local law for adults 21 years of age or older, to make industrial hemp legal under state and local law, and to control the commercial production and distribution of marihuana under a system that licenses, regulates, and taxes the businesses involved. The intent is to prevent arrest and penalty for personal possession and cultivation of marihuana by adults 21 years of age or older; remove the commercial production and distribution of marihuana from the illicit market; prevent revenue generated from commerce in marihuana from going to criminal enterprises or gangs; prevent the distribution of marihuana to persons under 21 years of age; prevent the diversion of marihuana to illicit markets; ensure the safety of marihuana and marihuana-infused products; and ensure security of marihuana establishments. To the fullest extent possible, this act shall be interpreted in accordance with the purpose and intent set forth in this section.

The implementation of the Act is left to the Department of Licensing and Regulatory Affairs, including the licensing of dispensaries.

Notably absent from the Act are any provisions that pertain to civil liability that arises or may arise from the sale or distribution of marijuana that causes personal injury. While it is possible the Legislature intends to deal with this issue pri-

or to the issuance of licenses in December 2019, currently it has provided no direction on how to handle these situations. Thus, practitioners that either defend or consult with dispensaries are left to manage this landscape themselves.

Parallels to Alcohol

With the potential for the use (or misuse) of marijuana to cause personal injury, parallels can be drawn between its consumption and the consumption of alcohol. As noted above, the Act does not provide for a framework for the identification of liability for the sale or distribution of marijuana that leads to personal injury.

In the vacuum that has been legislatively created, one could be tempted to liken the liability related to the distribution of marijuana to the liability related to the distribution of alcohol. In Michigan, liability for the improper distribution or service of alcohol to an allegedly intoxicated person is governed by the Dram Shop Act. The elements for a claim under the Dram Shop Act are as follows:

1. the immediate tortfeasor was an intoxicated person;
2. defendants, or their agents, sold intoxicating liquors to the tortfeasor;
3. as a result of the sale, the tortfeasor continued in an intoxicated condition until the time of the accident; and
4. the intoxication was the cause or contributing cause of plaintiff's injury.

While it is certainly understandable why one might conflate the service of marijuana with the service of alcohol, the Dram Shop Act pertains only to "intoxicating liquors." Additionally, the Social Host Liability Doctrine only pertains to those who supply liquor to minors. See, *Longstreth v Gensel*, 423 Mich 675; 337 N.W.2d 804 (1985). Therefore, while there may be parallels between the distribution and service of alcohol and the distribution and service of marijuana, the current state of the law does not address the provision of intoxicating substances that are not liquor (i.e., marijuana).

Instead, it appears that common law negligence principles will apply when marijuana is the intoxicating substance at

issue. This is certainly subject to change given the recency of the legalization of marijuana and the continued legislative discussions about the same. But, given that marijuana was recently a Schedule 1 substance, the common law does not provide any more guidance than the Act.

That said, dram shop limitations on liability and provisions of the Dram Shop Act that permit indemnification from the allegedly intoxicated person and preclude the dismissal of him or her from the suit until it is fully and finally resolved are not benefits that a marijuana distributor can rely upon to share or transfer risk. That leaves open the question of whether there are other methods of risk sharing that a marijuana dispensary can use to limit or completely transfer liability should it be named in a personal injury negligence matter.

Other Theories of Indemnification – Common Law

Marijuana dispensaries, with a lack of a statutory framework to share risk, may be tempted to limit liability at the point of sale of their goods or thereafter with one of Michigan's indemnity theories, including common law or contractual indemnity.

“Common law indemnification is available only if the party seeking it is not actively negligent.” *Palomba v City of Detroit*, 112 Mich App 209 (1982). The key focus here is whether the sale or distribution of marijuana is “active negligence.” Indeed, as risk transfer and indemnity attorneys know, in common law indemnity situations determining whether the underlying complaint alleges active negligence is of vital importance to the success of such a claim. Given the enactment of statutory law that permits the sale and use of marijuana, it is unlikely that its sale is active negligence in the context of State law. That said, the issue is not as clear cut as one would expect since the sale of marijuana is currently a Federal crime. Regardless, it seems evident that if the sale is more than the amount permitted by law, that is likely to be active negligence. Accordingly, it is important to understand what the statute permits because if a potential client's sale of marijuana complies with the statutory scheme, common law indemnity *may* provide respite.

Contractual Indemnification

Further, there is an opportunity at the point of sale to include indemnity language and waivers of liability. Assuming that the indemnity language is properly displayed, the purchaser is aware of it, and there are no issues with adhesion contracts, a contract that seeks to shift liability to a purchaser *may* be valid. In fact, the Act states as much – “It is the public policy of this state that contracts related to the operation of marihuana establishments be enforceable.” However, “an adhesion contract is simply a type of contract *and* is to be enforced according to its plain terms just as any other contract.” *Rory v Continental Ins. Co.*, 473 Mich 457 (2005). Accord-

ingly, the Act and relevant case law provides safe harbor for the argument that a point of sale indemnification provision is enforceable as written.

Regardless, transferring risk in this manner is not guaranteed. First, an innocent third party may still have a cause of action for negligence against a dispensary, and certainly that is a claim that would likely be brought given the deeper pockets a business is likely to have. Seeking indemnity against a purchaser and allegedly intoxicated individual likely does not provide much of an avenue for recovery, making an indemnity theory practically worthless from the perspective of the dispensary.

It is noteworthy to mention that in the circumstances that it does make sense to pursue indemnity, there is the potential that such an agreement could be invalid as against public policy, regardless of the impact of MCL 333.27960 since public policy is also anti-indemnity. See, e.g., *Chrysler Corp v Brencal Contractors Inc.*, 146 Mich App 766 (1985). (When there is an ambiguity in a contract, the language is “construed most strictly against the party who drafts [it] and against the party who is the indemnitee.”) Thus, while risk transfer is always an avenue to pursue, the knowledgeable practitioner will advise her client that indemnity may not result in its insulation should an innocent third party obtain a judgment.

Insurance Coverage

There are coverage issues that must be considered in standard policies, including CGL policies. Most policies have exceptions to coverage that may impact a dispensary from obtaining coverage for personal injury claims.

The first that comes to mind is the exclusion for illegal activities. Under Michigan law, this exclusion would likely not apply, although the continuing illegality of marijuana use under federal law makes the answer less clear.

But another exclusion, often overlooked, that could apply in either state or federal court when a dispensary seeks coverage, is the Products-Completed Operation Hazard exclusion that is found in form CGL policies.

Coverage C Medical Payments

2. Exclusions

We will not pay expenses for “bodily injury”:

* * *

f. Products-Completed Operations Hazard

Included within the “product-completed operations hazard.”

Since the insurance industry is continuing to evolve in this field, a full analysis of all potential coverage issues would be speculative at best for claims arising in Michigan. However, this topic is ripe for discussion once dispensaries are licensed

as there are sure to be issues with the implementation of insurance coverage, as has occurred in other states.

For example, on the question of the illegal activities exclusion, consider *Green Earth Wellness Center, LLC v. Attain Specialty Insurance Company*, 163 F.Supp3d 821 (D.Colo. 2016). (A claim for breach of insurance contract could continue to trial and the insurance policy was not void as against federal public policy, reasoning that a recent erosion of federal public policy suggests that the federal Controlled Substances Act will not be enforced in states that have approved recreational medical marijuana.)

Of note, there are specialty lines that do provide coverage for dispensaries for recreational use that are currently available in states where dispensaries are operational. As those policies are not yet available or needed in Michigan, it is also speculative to presume the contents of them at this time.

Conclusion

While the prospects of mainstream recreational marijuana use are becoming clearer, the liability that businesses such as dispensaries may endure is hazy. There is a framework in place

under the Dram Shop Act that could be a guidepost for issues such as liability and cost sharing, but until Legislative action is taken, cutting through that haze of liability remains difficult. Therefore, common law and traditional negligence claims will fill the void, with the opportunity for clever practitioners to utilize those traditional avenues to protect their clients before their ambitions go up in smoke. ■

About the Authors

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No-Fault Reform 2019: A Counterpoint

By Jack L. Hoffman, *Kuiper Kraemer PC*

“It wasn’t him, Charley. It was you.”
Marlon Brando as Terry, from *On the Waterfront*

I read with interest Wayne Miller’s article in the July 2019 issue of the *Journal of Insurance and Indemnity Law*, “No-Fault Reform 2019: Shame.”

I consider Wayne one of the finest attorneys and gentlemen that I have had the privilege to meet. He is an articulate advocate for the health services industry. But he is that, an advocate. I offer a counter-point.

In truth, the original no-fault act was reasonably well crafted to achieve its goals. What brought the system to the point of unworkability was a spirit of legal skepticism of Enlightenment values which enticed the Michigan judiciary to in effect amend the statute, in violation of separation of powers, in the interest of the health services industry. Having achieved hegemony, the health services industry bitterly opposed necessary reforms, such as a medical fee schedule, which would have preserved the system. Having done everything in its power to divert the act from its original purposes and turning the system into a rainy day fund for the health services industry to cover perceived losses in other lines of business, the industry and Wayne now decry the reform act as a failure of the legisla-

tive process. Given the history of the application of the act by the courts, it is more accurate to describe the collapse of the original system as a failure of the judicial branch to exercise judicial self-restraint and deference to the legislature.

I commence with legal skepticism because I understand that to be the root of the problem. A primary source on legal skepticism is Judge Posner’s 1988 article in the *University of Michigan Law Review*, *A Skeptical Jurisprudence*. There the distinguished judge, economist and philosopher of law lays down the credo of the legal skeptic: Facts are real, values are not. Since values are not real, there is no reason for an intelligent judge to be bound by the Enlightenment based judicial values of judicial self-restraint, deference to the legislature, separation of powers, impartiality, respect for the law, and a government of laws and not men.

In the last analysis, as that other prominent legal skeptic Oliver Wendell Holmes famously pronounced, the law is nothing but a prediction of what judges will do. This of course gives no guidance to a judge trying to decide a case, because it merely tells the judge to predict what he or she is going to

do anyway. Little wonder that such a legal philosophy induces judges to rule as they wish, in disregard of traditional limitations on judicial power in the English-American constitutional system of mixed government.

Having achieved hegemony, the health services industry bitterly opposed necessary reforms, such as a medical fee schedule, which would have preserved the system.

Consider the opinion of the Court of Appeals in *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co*,¹ a key opinion in the judicial creation of the provider cause of action for no-fault benefits. As is now universally recognized, such a cause of action had no basis in the text of the statute but was a result of judges with a turn toward legal skepticism judicially amending the statute to bring it into line with what they considered good policy. This is clearly shown by the summary of the holding at the end of the opinion, for example, where the court said “the no-fault act may not be used by a no-fault insurer as a vehicle to shift the burden of the injured person’s economic loss to a health care provider or as a weapon against rightful payees to a payee’s unjustified economic detriment.”² The whole analysis is based on the policy preferences of the court, and not at all on the text of the statute.

In reality the provider cause of action dissected by the Supreme Court in *Covenant Med Ctr, Inc v State Farm Mut Automobile Ins Co*³ is only the tip of the iceberg. Legal skepticism has penetrated even more deeply at the trial court level. Highly significant in this context is what evidence is relevant to the issue of what is a reasonable charge as that term is used in sections 3107(1) (a) and 3157 of the act. In the real world, vast amounts of health services financial data are available in the public domain. The data is hospital specific and highly detailed.

Hospital services are categorized into several hundred medical service diagnostic related groups (MS-DRG). For example, cervical spinal fusion without complications or comorbidities is coded as MS-DRG 473. Publicly available data available from such vendors as American Hospital Directory give for any specific hospital, the hospital average gross charge, average cost of providing the service, and average payment for this orthopedic surgery service. This publicly available data on hospital charges is used in the industry as a matter of course in assessing issues of health services finance. But in general Michigan trial judges do not allow the jury to hear the evidence in a no-fault case. Why not? Most trial judges have been convinced by advocates for the health services industry that obiter dicta in Michigan appellate opinions are superior in authority to the text of the statute. Underlying the approach is again the legal

skeptical position that, at the end of the day, the law is what the judge says it is. Forget separation of powers, checks and balances, and a government of laws and not men.

It gets worse. Not only did the Michigan judicial branch create a provider cause of action with no basis in the statute, and exclude public financial data used in the industry itself from the reasonableness consideration, again with no basis in the statute. In this context the judiciary has also departed from the previously universally accepted principle that an insurer is not unreasonable if it raises in good faith legitimate questions of fact, statutory construction, or constitutional law. Indeed, so far did the judicial paradigm of provider-centric application of the act progress, that insurer counsel have regularly been sanctioned for asking what is the basis for the paradigm in the text of the statute?

Given the combination of a powerful industry and a judicial skepticism about constitutional limitations on judicial power, is it any wonder that medical charging in the no-fault context has raged out of control? Provider and provider counsel freely admit that charges payable by no-fault insureds and insurers are two, three, four, or five or more times the payment received by the hospital for from other payers for the same service, and a similar mark up over costs. To the provider industry, this is not bug of the system, but a feature. They celebrate it.

Wayne in his article looks nostalgically back to the good old days when the Michigan no-fault system was given high marks for effectiveness. No longer. What changed? Hospital gross charges.

In 1960, “[t]here were no discounts; everyone paid the same rates”—usually cost plus ten percent. But as some insurers demanded deep discounting, hospitals vigorously shifted costs to patients with less clout. Since uninsured patients are protected in this Darwinian marketplace by neither insurers nor regulators, hospitals are loosed to charge what they will. The egregious failure of the hospital market is revealed by the astonishing differences between what hospitals nominally charge and what insured patients pay. Insurers pay about forty cents per dollar of listed charges. Thus hospitals bill uninsured patients 250% more than insured patients. This disparity has exploded over the past decade: since the early 1990s, list prices have increased almost three times more than costs, and markups over costs have more than doubled, from 74% to 164%.⁴

Since Professor Hall’s 2008 study, the situation has only become more extreme, by orders of magnitude. Consider this. With regard to Worker’s Compensation a medical fee schedule was adopted in 1982. The Workers Compensation system functions as intended. The no-fault system did not. The differ-

ence is the fee schedule.

The health services industry has not only deployed its substantial forces in the legal field but in the political field as well. For decades, provider funded advocacy groups such as the Coalition Protecting Auto No-fault have bitterly and successfully contested any legislative reforms to adjust the system to the new reality. Is it any wonder that when the dam finally broke, some of the good was swept away with the bad?

Some of the criticisms of the reform act are well taken. Speaking for myself, I believe the option for lifetime caps was ill-considered, and probably unnecessary in view of the fee schedules going into effect on July 1, 2021.

But when the health services industry starts pointing fingers, my reaction is “Look in the mirror.” ■

About the Author

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Endnotes

- 1 250 Mich App 35; 645 NW2d 59 (2002)
- 2 *Id.*, 250 Mich App at 43-44.
- 3 313 Mich App 50; 880 NW2d 294 (2015)
- 4 “Patients as Consumers: Courts, Contracts, and the New Medical Marketplace,” Hall and Schneider, 106 Mich LRev 643, 663 (2008).



No-Fault Reform—The End of an Era – Part III Unintended Consequences

Ronald M. Sangster, *Law Offices of Ronald M. Sangster PLLC*

Author’s Warning – the opinions expressed herein are solely those of the author, and do not necessarily represent the opinions of the MDTC, the MAJ, the State Bar of Michigan, the defense bar, the plaintiff’s bar, the neighborhood bar, the insurance industry, the medical industry, the auto industry, the Republican party, the Democratic party, the Libertarian party, or those attending your holiday party!

In our last two articles, the author has attempted to highlight what could best be described as “holes” in the recently passed nofault reform amendments, SB 1 and HB 4397, now 2019 PA 21 and 22, respectively. Given that some of the provisions have already taken effect, and claims are being filed, it is becoming more apparent that the Legislature needs to revisit this area, once again, in order to correct some of the glaring inequities that have become apparent since June 11, 2019, when these bills became law. The following article is designed to highlight some of those areas that require immediate attention, in the opinion of the author, before further damage is done to the nofault system.

Part I – When Is A Choice Not A Choice?!

In the two earlier articles, the author described the situation that would be faced by motorcyclists after July 1, 2020, when the PIP choice provisions begin to phase in with policies issued or renewed after that date. Because the priority provisions have not changed, the motorcyclist is now at the mercy

of whatever PIP coverage limits may have been obtained by the owner of the motor vehicle involved in the accident. However, the problem extends beyond motorcyclists, and includes occupants of vehicles operated in the business of transporting passengers, and employees and their family members who are occupying employer-furnished vehicles. Let us examine these situations in further detail.

Part A – Motorcyclists

As noted above, the priority provision for motorcyclists involved in an accident with a motor vehicle, MCL 500.3114(5)(a) remains unchanged. A motorcyclist injured in a motor vehicle accident will first turn to the insurer of the owner of the motor vehicle involved in the accident for payment of his or her nofault benefits. Next in line is the insurer of the operator of the motor vehicle involved in the accident. Third in line, of course, is the motor vehicle insurer for the operator of the motorcycle.

Given the inherent risks of operating a motorcycle, the motorcyclist is more apt to sustain serious injuries if he or she is involved in an accident with a motor vehicle. The author, for one, will be obtaining lifetime, unlimited PIP coverage, which I would expect would cover me whether I am driving a car, riding a bicycle, walking across the street, or riding one of my motorcycles.

However, if the owner of the motor vehicle involved in the accident is a Medicaid recipient with \$50,000.00 worth of PIP coverage, the motorcyclist will be bound by the coverage level chosen by the owner of the motor vehicle, and would not have access to the lifetime, unlimited coverage available under his or her own motor vehicle policy, as the law is presently drafted. Even if the owner or registrant of the motor vehicle has opted to purchase \$250,000.00 worth of coverage, the motorcyclist may be stuck at that level of coverage, even if the motorcyclist has opted for lifetime, unlimited benefits on his motor vehicle insurance policy.

Part B – Vehicles For Hire

When the NoFault Act was originally drafted, occupants of motor vehicles operated in the business of transporting passengers always received their benefits from the insurer of the motor vehicle they were occupying. Since then, the Legislature has carved out a number of exceptions, for passengers (but not operators) of certain vehicles, including government-sponsored transportation vehicles, school buses, charter buses, taxi cabs, and transportation network company vehicles, so that the passenger's own motor vehicle insurance policy (or that of a spouse or a domiciled relative) will pay first. However, passengers in other types of vehicles operated in the business of transporting passengers, such as ambulances, limousines, party buses, non-emergency medical transportation vehicles, and airport shuttles receive their PIP benefits from the insurer of the vehicle they are occupying. Drivers of all vehicles being operated in the business of transporting passengers likewise receive their benefits from the insurer of the vehicle itself. See MCL 500.3114(2). Again, the nofault amendments did not change these priority provisions.

Like the prudent motorcyclist referenced above, assume that a person secures a policy providing for lifetime, unlimited nofault benefits, for the protection of himself and his family. His daughter, a senior in high school, rents a party bus with some friends to go to the prom. On the way to the prom, the party bus is involved in a serious auto accident, and the daughter is catastrophically injured. The owner of the party bus, though, has only opted to purchase PIP coverage in the amount of \$250,000.00. Those limits are quickly exhausted, yet under the way the bill is set up, the injured daughter cannot access her father's lifetime, unlimited PIP coverage. As a passenger in the party bus, she is bound by whatever PIP

coverage limits were chosen by the owner of the vehicle being operated in the business of transporting passengers.

Along these same lines, imagine that a person is employed driving a SMART bus in the metro Detroit area. The SMART bus system decides to opt for \$250,000.00 in PIP coverage limits. The bus driver, though, is seriously injured in a motor vehicle accident, and even though the bus driver may have opted for lifetime, unlimited coverage on her own vehicle, the current law has no mechanism for her to access that coverage because her household insurer is simply a lower priority insurer.

Part C – Employer-Furnished Vehicles

Imagine that you work for a company that still provides company cars to their employees. However, the owner of the company opts to purchase \$250,000.00 in PIP coverage. Pursuant to MCL 500.3114(3), the insurer of the employer-furnished vehicle occupies the highest order of priority for payment of the nofault benefits at issue. Even if the employee has opted to purchase lifetime, unlimited benefits on his own motor vehicle, he has no way of accessing that coverage because his motor vehicle insurer is a lower priority insurer than the insurer of the employer-provided vehicle.

Part D – Proposed Solution

HB 4812 has been introduced, which would change the order of priority for motorcyclists back to where it was before 1980, so that the motorcyclist's motor vehicle insurer would occupy the highest order of priority for payment of the nofault benefits at issue. While it would take another article to explain the "back story" behind the shift in the priority provisions that took place in 1981, it is the author's opinion that such a change would be bad public policy. HB 4812 also does not do anything to address the situations where passengers in certain vehicles for hire, operators of all vehicles for hire, and employer-furnished vehicles find themselves in, in the event they have opted to purchase lifetime, unlimited coverage for their own automobiles, and yet are bound by whatever PIP coverage choices were made by the owners of the motor vehicles occupied or involved in the accident. These individuals may have made a choice to fully protect themselves by purchasing lifetime, unlimited benefits, but their choice means nothing in these circumstances.

The legislative fix is very simple – a law needs to be enacted to make it clear that if a person is entitled to benefits under MCL 500.3114(2), MCL 500.3114(3) or MCL 500.3114(5), and they have opted to purchase higher PIP coverage limits on their own policies under MCL 500.3114(1), then the injured person's insurer would receive a set-off for the benefits paid by the higher priority insurer, and after that higher priority coverage is exhausted, then the injured person's own personal motor

vehicle insurance policy kicks in. Essentially, the person's own personal motor vehicle insurance coverage would operate as excess or secondary insurance, and only kicks in after the underlying limits are exhausted. Furthermore, the amounts paid by the highest priority insurer should be applied toward the personal insurer's MCCA self-retention limit. The proposed statute should read something like this:

"If an injured person claiming benefits under MCL 500.3114(2), MCL 500.3114(3) or MCL 500.3114(5) has higher PIP coverage limits available to them, whether individually or through a spouse or relative of either domiciled in the same household pursuant to MCL 500.3114(1), then the insurer for the injured person, his or her spouse or a relative of either domiciled in the same household shall receive a credit for the amount of nofault benefits being paid by the insurer paying pursuant to MCL 500.3114(2), MCL 500.3114(3) or MCL 500.114(5). Such insurer shall commence payment of benefits under the policy after the limits of the insurer paying under MCL 500.3114(2), MCL 500.3114(3) and MCL 500.3114(5) have been exhausted. Any amounts paid by an insurer paying under MCL 500.3114(2), MCL 500.3114(3) and MCL 500.114(5) shall be added to any amounts paid by the injured person's insurer under MCL 500.3114(1) for purposes of reimbursement by the Michigan Catastrophic Claims Association for benefits paid in excess of the amounts set forth in MCL 500.3104."

A few examples will clarify how this proposed amendment would work.

A motorcyclist obtains lifetime, unlimited PIP coverage on his own personal motor vehicle. While operating his motorcycle, he is involved in an accident with a motor vehicle whose owner has opted to procure \$50,000.00 in PIP coverage. Due to the catastrophic nature of the injuries suffered by the motorcyclist, the \$50,000.00 in PIP coverage is exhausted after 1 month. Once the coverage is exhausted, the motorcyclist's personal motor vehicle insurer commences payment of the "allowable expenses" at issue. Once the individual's personal insurer pays \$530,000.00, thereby resulting in a total payout of \$580,000.00 – the current MCCA self-retention limit- a motorcyclist's motor vehicle insurer is reimbursed dollar for dollar by the MCCA.

To use another example, imagine that George works for SMART. SMART has \$250,000.00 of PIP benefits on their vehicles. George is catastrophically injured while operating a bus. SMART's insurer pays the first \$250,000.00. George's personal motor vehicle insurer then pays \$330,000.00, bringing the total payout to \$580,000.00. Any amounts paid by George's insurer above \$330,000.00 would be reimbursed by the MCCA.

Finally, with regard to the "party bus" scenario, discussed above, if the party bus operator opted to carry \$500,000.00 worth of PIP coverage, and the daughter is catastrophically injured, the insurer of the party bus would pay the first \$500,000.00 in "allowable expense" coverage. The daughter's father's insurer then pays \$80,000.00, thereby satisfying the current MCCA self-retention limit of \$580,000.00. At that point, the MCCA will reimburse the father's personal motor vehicle insurer for the benefit payments made.


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Part II – Non-Resident Exclusion Affects Michigan Residents When Out of State.

Even though the intent of the legislation was to preclude out-of-state residents from recovering Michigan nofault benefits, the new law operates to deprive Michigan residents, injured while occupying a motor vehicle outside the state of Michigan, from recovering nofault benefits.

Even a cursory glance of the nofault amendments makes it clear that one of the intended results was to prevent out-of-state residents from recovering nofault benefits, except under very limited circumstances. See e.g., MCL 500.3113(c), which bars out-of-state residents from recovering Michigan nofault benefits and MCL 500.3163, which provides that insurers admitted to do business in Michigan are no longer obligated to provide Michigan nofault benefits to its out-of-state residents traveling in this state. See also the changes in MCL 500.3111, which govern Michigan residents involved in motor vehicle accidents occurring outside of Michigan. However, these changes, when coupled with the changes in priority (likewise discussed below) operate to deprive Michigan residents, who previously would have been entitled to recover nofault benefits, from recovering nofault benefits if they are injured in an accident occurring outside the State of Michigan.

Take, for example, Bobby, Sue and their three children who live in Detroit. Bobby and Sue have been living together for ten years. By all appearances, Bobby, Sue and their three children appear to be a traditional “Ozzie & Harriet” family in everything but a marriage license! Bobby, Sue and their three children travel to Toledo to take in a Toledo Mud Hens baseball game. While traveling in their car in Toledo, Bobby, Sue and the three children are all seriously injured.

Under the old order of priority, all five occupants are entitled to Michigan nofault benefits under MCL 500.3111, as Bobby is the named insured on a nofault policy, his three children are relatives who are domiciled with him, and Sue recovers benefits because she is the occupant of a motor vehicle whose owner or registrant was insured by a Michigan nofault policy. As for priority, she used to turn to Bobby’s insurer, as the insurer of the owner of the motor vehicle she was occupying at the time of the accident, under the previous version of MCL 500.3114(4).

Under the current system, she is still entitled to receive nofault benefits under MCL 500.3111, because she is a Michigan resident and is occupying a motor vehicle whose owner (Bobby) was insured under a Michigan nofault insurance policy. However, under the current version of MCL 500.3114(4), she no longer turns to Bobby’s insurer for payment of her nofault benefits. She turns to the Michigan Assigned Claims Plan (MACP). However, the statutory provisions governing the operation of the Michigan Assigned Claims Plan make it clear that it does not provide coverage for accidents occurring outside the State of Michigan! Sue is entitled to benefits but

she has nowhere to go! Certainly, it could not have been the intention of the Legislature to deprive Sue of benefits that she otherwise would have been entitled to receive under the old system. Therefore, the Legislature needs to step in and amend the provisions governing the operation of the MACP to make it clear that Michigan residents, like Sue, who are entitled to benefits under MCL 500.3111 will receive their benefits from the MACP even for accidents occurring outside the State of Michigan. A proposed legislative amendment would look something like this:

“A resident of this state, entitled to recover benefits under MCL 500.3111 for accidents occurring outside the State of Michigan shall receive their benefits from the Michigan Assigned Claims Plan., if they are not entitled to benefits from another insurer.”

Part III – The Impact of the Priority Changes in MCL 500.3114(4) and MCL 500.3115(1)

As noted in our prior articles, the nofault reform amendments re-write the priority provisions applicable to occupants and non-occupants of motor vehicles who do not have a policy of insurance available to them in their household, either individually or through a spouse or domiciled relative. Effective June 11, 2019, those individuals now turn to the Michigan Assigned Claims Plan, where their “allowable expense” benefits are now capped at \$250,000.00. The problem is that under the terms of the insurance policy issued to the owner of the motor vehicle occupied, these “strangers to the insurance contract” are still considered to be “insureds” under the policy. So which controls – the new statute or the policy language?

The MACP has taken the position that it is accepting these claims, subject to a review of the policies issued to the owners of the motor vehicles involved in these accidents, in order to determine whether or not the policies would arguably provide greater coverage than was available through the MACP. If, for example, the policy contains a provision which provides that the policy provisions change automatically with any change in the insurance code, the MACP will accept coverage without question, because the policy provisions have obviously changed effective June 11, 2019.

On the other hand, if the policy itself makes no reference whatsoever to the code, then the policy will be construed as providing broader coverage, and the claim will be returned to that insurer for payment.

These are extreme examples, and the author respectfully submits that very few, if any, policies have either of these policy languages. Most policies have language to the effect that the policy is “subject to the code.” It is an open question as to whether or not the phrase “subject to” is a statement of limitation on coverage. Certainly, two attorneys reading this same language may come to different conclusions, as could two circuit court judges reviewing the identical policy language. All

of this chaos results because the insurers have not yet had time to get the amendatory endorsements filed with the Department of Insurance and Financial Services.

Don't think it makes a difference? Think again. Imagine a pedestrian, Brenda, who is struck by a motor vehicle while walking across the street. Brenda does not own a motor vehicle. Brenda is not married and has no relatives in her household who own a motor vehicle. Mike owns the motor vehicle that strikes Brenda. Under Mike's policy, she qualifies as an "insured" because she is involved in an accident with "your covered auto" under Mike's policy. Under the policy, she is entitled lifetime, unlimited nofault benefits, because the accident occurred before July 1, 2020. However, under the MACP, her "allowable expense" benefits are capped at \$250,000.00. Imagine that Brenda is catastrophically injured, and her initial hospitalization expenses alone exceed \$250,000.00. What if Mike's insurer determines that its policy language is not clear, and decides to commence payment of Brenda's nofault benefits? Imagine that three years from now, the MCCA reviews the policy and determines that the claim should have been referred over the MACP in the first place, and refuses to reimburse Mike's insurer. What then?

Or imagine that Mike's insurer continues to pay on the claim, and after three years, the insurer has paid out \$750,000.00. A Court of Appeals' panel then interprets similar policy language and determines that the policy coverage automatically changed when the law changed, at which point the insurer sues the MACP for reimbursement. While the MACP may reimburse for the first \$250,000.00 in "allowable

expense" coverage, the insurer which, in good faith, paid benefits is now out \$500,000.00! The NoFault Act was originally enacted to provide some certainty when it came to payment of nofault benefits, yet under this scenario, the outcome is anything but certain.

Proposed Legislative Fix

This fix is easy, but the Legislature needs to act very quickly. The Legislature needs to make a choice – either delay the effective date of these priority changes to accidents occurring after July 1, 2020, to give insurers time to get their amendatory endorsements in order, or indicate that notwithstanding any policy provisions to the contrary, those Claimants entitled to benefits under MCL 500.3114(4) and MCL 500.3115(1) automatically go to the MACP for payment of their benefits. The formal legislative proposal should read something like this:

"The amendments to MCL 500.3114(4) and MCL 500.3115(1) apply to accidents occurring after July 1, 2020."

That way, claims that are currently being handled by the MACP, for accidents occurring after June 11, 2019, would be returned to the insurer of the owner of the motor vehicle occupied by the injured Claimant, or involved in the accident with the injured non-occupant.

Alternatively, MCL 500.3114(4) and MCL 500.3115(1) could be amended to include the following introductory clause:

"Notwithstanding the provision of any insurance policy to the contrary . . ."

Either way, it is imperative that some sense of certainty be restored to the priority provisions.

These are just a few of the areas that need to be corrected by the Legislature, preferably before the end of the year. The proposed amendments to the priority provisions should be addressed immediately by the Legislature, so that the MACP can return the claims to the prior insurers (if the implementation of the priority changes is delayed until after July 1, 2020) or the MACP automatically takes those cases without getting bogged down in policy interpretation issues. The author respectfully suggests that the Legislature make a call – one way or the other – to restore some level of certainty.

There are certainly other areas that need to be addressed, and as they arise, those will be discussed in forthcoming articles. For the time being, to mis-quote Bette Davis (as many people do), "Buckle your seatbelt, it's going to be a bumpy ride." ■



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Selected Insurance Decisions

By Deborah A. Hebert, *Collins, Einhorn, Farrell PC*

Michigan Supreme Court

UM hit-and-run coverage – what it means to “cause an object to hit” the insured

Drouillard v American Alternative Ins Corp
___ Mich ___; 929 NW2d 777 (2019)

In this case for uninsured motorist coverage based on an accident with a “hit-and-run” vehicle, the Supreme Court tackled what it means for the unidentified vehicle to “cause an object to hit” the insured or the insured’s vehicle. The insured struck a piece of drywall in the road after it fell off an unidentified truck. The Court of Appeals held that the drywall was a stationary object that did not hit the vehicle. Rather, the vehicle hit the drywall. The Supreme Court reversed, holding that “hit” means the object came into contact with the insured. Because the drywall came into contact with the insured vehicle, uninsured motorist coverage applied under the terms of the contract. The dissenting opinion would hold that a stationary object cannot “hit” a person or another object.

This case holds that an insurer may not cancel a policy “by sending the statutorily required ‘notice of cancellation’ to the insured before grounds for cancellation have occurred.”

Michigan Court Of Appeals – Published Decisions

10-day notice of cancellation must be sent after the basis for the cancellation

Yang v Everest National Insurance Company
___ Mich App ___ (2019)
Docket No. 344987
Released August 27, 2019
Motion for reconsideration pending

This case holds that an insurer may not cancel a policy “by sending the statutorily required ‘notice of cancellation’ to the insured before grounds for cancellation have occurred.”

Everest included a notice of cancellation with its billing invoices advising that coverage would be cancelled if payment was not timely received. MCL 500.3020 requires at least ten days’ notice of cancellation by first class mail if cancellation is for non-payment. A bill mailed before the payment is late does not satisfy the cancellation requirements of Michigan insurance code.

Michigan Court Of Appeals – Unpublished Decisions

Contractual tolling periods run until there is a clear denial of the claim

Tomasko v Auto-Owners Insurance Company
Docket No. 343974
Released July 18, 2019

This homeowners policy contained a one-year period of limitations for claims of property loss. Suit had to be filed within one year after the loss or damage occurred, with a tolling period from the time Auto-Owners was notified of the claim until it denied coverage. Under Michigan law, denials have to be “explicit and unequivocally impress upon the insured the need to pursue further relief in court” in order for the notice to be deemed a formal denial. Auto-Owners sent two letters advising of the limited coverage under plaintiff’s policy. The first letter invited the insured to produce additional evidence of a covered claim, so it was not considered a formal denial. The second letter did meet the criteria of a formal denial because it conveyed the lack of coverage. Because the insured failed to timely file suit after the second letter, coverage was properly denied.

New endorsement in renewal policy is effective when served on the insured’s agent

Amco Insurance Company v Invecor LLC
Docket No. 342498
Released July 25, 2019

During the policy period in question, Invecor’s policy with Amco expressly excluded coverage for claims involving the violation of statutes governing unsolicited emails, faxes, phone calls or other methods of communication. Invecor claimed it

was unaware of the exclusion, which was added by way of an endorsement to a renewal policy mailed to the insurance agent. Because the independent agent was the policyholder's agent, notice to that agent was noticed to the insured. And there was no dispute that the endorsement was added to the policy and barred coverage for the underlying claim.

Estoppel principles did not apply to extend coverage to the LLC because an insured's reasonable expectations are irrelevant to the coverage afforded by an unambiguous contract.

Commercial policy issued to corporate entity did not cover later-formed LLC

Speckin Forensics LLC v Auto-Owners Insurance Company
Docket No. 344012
Released August 13, 2019

Because the commercial policy was issued to Speckin Forensics Laboratories, Inc., which was incorporated in 1996 and dissolved in 2014, coverage did not apply to Speckin Forensics, LLC, formed in January 2010. The two companies were separate entities and only one was named on the policy as an insured. Estoppel principles did not apply to extend coverage to the LLC because an insured's reasonable expectations are irrelevant to the coverage afforded by an un-

ambiguous contract. Nor was there any mutual mistake. The LLC did not have coverage for the claims asserted in the underlying matter.

Federal District Court – Eastern District of Michigan

Questions of fact about the effect of insured's conduct on coverage

Karoumi v Allstate Vehicle and Property Ins Co
Case No. 18-cv-10379
August 21, 2019

The insured homeowners claimed water damage as the result of a broken water line under the kitchen sink while they were away on a trip. Allstate denied coverage on the ground that the damage was not accidental. Allstate's claims investigation revealed that the insureds submitted a nearly identical claim to a prior insurer, and sought essentially the same excess recovery for alternative living arrangements with a relative. Allstate also denied coverage for breach of the contract terms requiring insureds to retain the damaged property or otherwise document the loss, and allow Allstate the opportunity to inspect. The insureds failed to retain the broken pipes and arranged for the repairs before Allstate had a chance to inspect. The court found questions of fact about whether Allstate reasonably required the insureds to retain the damaged pipes and whether the failure to do so actually impeded Allstate's ability to investigate the claim. ■





Legislative Update: Back From Recess – On to the Budget and Roads

By Patrick D. Crandell,
Collins, Einhorn, Farrell PC

With the Legislature back from its summer recess, the focus now is on passing a budget and addressing road funding (together or as separate measures). And with the No-Fault amendments in the rear-view mirror, work in the insurance committees has slowed – neither committee has met since June. But there has been some activity on a few insurance-related bills since the last update:

- **Felony and Licensing** – HB 4044 limits the effect of a felony on an insurance producer’s licensing (only felonies involving dishonesty or breach of trust would impact a producer’s license) *Passed the House (109-0) on 6/20/19; Referred to the Senate Insurance Committee on 8/20/19*
- **Reimbursable Chiropractic expenses** – HB 4449 removes certain chiropractic services from the list of non-reimbursable personal injury protection benefits *House Insurance Committee adopted H-1 Substitute on 4/18/19; Referred to House Committee on Ways and Means on 6/20/19*
- **PIP Venue Requirements** – SB 292 requires the venue for all actions involving PIP benefits to be the county in which the injury occurred or in which the injured person resided *Reported out of the Senate Insurance Committee on 5/7/19; Reported out of the Senate Committee of the Whole and Placed on 3rd Reading of Bills on 5/7/19*
- **Insurance Fraud as Racketeering** – SB 295 amends the Penal Code to add insurance fraud to the definition of “racketeering” *Reported out of the Senate Insurance Committee on 5/7/19; Reported out of the Senate Committee of the Whole and Placed on 3rd Reading of Bills on 5/7/19*
- **PIP Priority Change** – HB 4812 modifies the priority of PIP benefit payments owed to a motorcycle operator involved in an accident with a motor vehicle
- **Vehicle Impoundment Prohibited** – HB 4909 prohibits law enforcement from seizing or impounding a vehicle because the operator doesn’t produce proof of insurance
- **Expansion of First Responder Fund** – HB 4934 extends the first responder presumed coverage fund to forest fire officers and fire/crash rescue officers who are exposed to job-related hazards and are diagnosed with certain cancers
- **Health Insurance and Contraceptives** – SB 388 requires health insurance policies providing prescription drug coverage to also cover contraceptive drugs, devices and products without copayment, deductible or coinsurance, except for certain religious employer-provided policies and grandfathered policies
- **Prohibition on Price Optimization** – SB 498 prohibits insurers from using price optimization in determining rates
- **Prohibition of Risk Territories** – SB 499 prohibits automobile insurers from grouping risk by territory
- **DIFD Posting of Insurance Rates** – SB 500 requires the Department of Insurance and Financial Services to yearly post to its website a comparison of insurance rates based on insurer filings; and provides for civil fines against insurers that knowingly provide false or misleading information to the Department
- **SB 528** – modifies the priority of PIP benefit payments owed to a motorcycle operator involved in an accident with a motor vehicle
- **SB 529** – requires automobile insurers to offer deductibles for PIP benefits ■

New Bills

Legislators continue to introduce new bills (988 in the House and 532 in the Senate), with only a few new referrals to the House and Senate Insurance Committees:

- **Cap on Cost of Insulin** – HB 4701 caps the amount (\$100) a health insurer can require an insured to pay for a 30-day supply of insulin
- **Deductibles for PIP Benefits** – HB 4734 requires automobile insurers to offer deductibles (at defined increments) for PIP benefits





ERISA Decisions of Interest

K. Scott Hamilton, *Dickinson Wright PLLC*, khamilton@dickinsonwright.com

Sixth Circuit Update

Denial of benefits not arbitrary and capricious where plaintiff's subjective pain complaints, although supported by some objective evidence, were contradicted by other medical evidence

Jackson v Blue Cross Blue Shield of Michigan LTD Program,
(6th Cir, Jan 22, 2019) (unpub),
Case No. 18-1542, 2019 WL 291966

Plaintiff complained of debilitating back pain that caused him to quit in his sedentary job as a telephone customer service representative. MRI scans after an injury in 2006 showed several herniated discs, and worsening pain cause him to stop working at the end of 2014. The plan administrator denied the plaintiff's claim for disability benefits, which the district court held was not arbitrary or capricious, and the Sixth Circuit affirmed.

The court first noted that “[t]o be sure, [the plaintiff's] MRI scans reveal disc degeneration and his electromyogram points to calf atrophy and absent reflexes,” and the plaintiff also complained of pain, prompting his treating physician to conclude he was disabled from even a sedentary role. The court stated that “[i]f this were the only evidence in the record, [the plaintiff] might have a valid claim that [the] denial was arbitrary and capricious.” But “the record also contains contrary evidence – including objective medical evidence

– showing that [the plaintiff] can fully perform sedentary work,” including a functional capacity evaluation (“FCF”) which revealed he could complete 88% of tasks needed for a sedentary job.

The claim administrator also relied on several physicians, including two who “reviewed all of [the plaintiff's] medical files and independently determined that the record lacked compelling objective evidence to support” the claim. Moreover, “the record reveals that [the administrator] took [plaintiff's treating physicians'] opinions seriously,” noting that the administrator's consulting physician opined there “is no reliable, valid and reasonably compelling evidence that [the plaintiff] has impairments preventing him” from working in a sedentary capacity, and another treating physician's conclusion of disability was “not supported by objective findings.” Although the consulting physicians disagreed with the plaintiff's treating physicians' ultimate conclusions, they did not ignore them.

Plaintiffs were independent contractors, not employees, and therefore not plan participants under ERISA

Jammal v American Family Ins Co,
914 F.3d 449 (6th Cir 2019)

In an interlocutory appeal, the Sixth Circuit in a 2-1 decision reversed the district court and held that current and former insurance agents were independent contractors, not employees, and therefore not entitled to ERISA benefits.



Nationwide Mut Ins Co v Darden, 503 US 318 (1992), set out the test “for determining who qualifies as an ‘employee’ under ERISA,” the crux of which is “the hiring party’s right to control the manner and means by which the product [of the individual’s work] is accomplished.” *Id.* at 323. Several factors go into that determination, such as location of the work, whether the hiring party can assign additional work to the hired party, the amount of discretion the hired party has, how they are paid, tax treatment of the hired party, and similar considerations. *Id.* Moreover, “an express agreement between the parties concerning employment status is also a relevant consideration.”

The district court held the plaintiff insurance agents were employees under the *Darden* test and therefore entitled to rights under ERISA. The district court certified its decision for interlocutory appeal. The Sixth Circuit reversed, clarifying the proper standard of review for decisions under the *Darden* test.

It first stated that it is clear that “the district court’s findings underlying its holding on each of the *Darden* factors are factual findings, and the court’s ultimate conclusion as to whether the plaintiffs were employees is a question of law.” But it noted “we have yet to clarify whether and to what extent a court’s conclusions about the individual factors that make up the *Darden* standard are factual or legal in nature.” Although “[o]ther circuits . . . have explicitly considered this question and have come down on the side of treating these as factual matters subject to review for clear error,” the Sixth Circuit parted company with its sister circuits and held that “we do not agree that a district court’s conclusion relating to the existence and degree of each *Darden* factor is entirely a question of fact.” Thus, the court held it is “appropriate for us to review *de novo* those determinations to the extent that they involve the application of a legal standard to a set of facts,” and “it is also appropriate for us to review *de novo* the district court’s weight assigned to each of the *Darden* factors, given the legal context in which the claim has been brought.”

Applying a *de novo* standard of review, rather than reviewing for clear error, the Sixth Circuit held that the “district court incorrectly applied the legal standards in determining the existence of the *Darden* factors relating to” two elements, and incorrectly weighed other relevant factors. It therefore concluded that the insurance agent plaintiffs were independent contractors, not employees, and were therefore not entitled to ERISA benefits or remedies.

The Sixth Circuit held that the “district court incorrectly applied the legal standards in determining the existence of the *Darden* factors

Plaintiff was entitled to attorneys’ fees under ERISA for arbitrary and capricious denial of benefits

Guest-Marcotte v Life Ins Co of N America,
(6th Cir, April 1, 2019) (unpub),
Case No. 18-1948, 2019 WL 1470910

Under ERISA, a “court in its discretion” may award attorney fees to a party if it achieved “some degree of success on the merits.” 29 USC §1132(g) and *Hardt v Reliance Standard Life Ins Co*, 560 US 242, 252 (2010). In the Sixth Circuit, whether to award attorneys’ fees is based on the “*King* factors” (*Sec of Labor v King*, 775 F2d 666 (6th Cir 1985), which are (1) the degree of the opposing party’s culpability or bad faith; (2) the opposing party’s ability to satisfy an award of attorneys’ fees; (3) the deterrent effect of an award on other persons under similar circumstances; (4) whether the party requesting fees sought to confer a common benefit on all participants and beneficiaries of an ERISA plan or resolve significant legal questions regarding ERISA; and (5) the relative merits of the parties’ positions.”

In *Guest-Marcotte*, the Sixth Circuit reversed the district court’s denial of attorneys’ fees in a 2-1 decision, stating the “facts of this case represent a paradigm case for when



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attorneys' fees are called for under 29 USC §1132(g).” It was “one of the rare instances” in which “a district courts’ denial of fees under this statute must be reversed.”

The court noted the claim administrator “denied benefits based on repeated and material misreading of the plan requirements,” denied benefits even though her employer “recognized her medical impairments supported her inability to perform her duties,” and misapplied a “non-existent objective-evidence requirement” that, although maybe not amounting to bad faith, “is about as culpable as it could otherwise get.”

Life insurance benefits properly denied under plan’s aerial navigation exclusion

Briggs v National Union Fire Ins Co of Pittsburgh, PA,
(6th Cir, May 23, 2019) (unpub),
Case No. 18-1828, 2019 WL 2234596

A participant in a life insurance plan designated his dependent as beneficiary, and his mother as contingency beneficiary. The plan participant and his dependent were killed in a small plane crash in which the plan participant was the pilot. The plan excluded accidental death and dismemberment (“AD&D”) coverage for loss caused by “flight in . . . any vehicle used for aerial navigation, other than as a fare-paying passenger on a scheduled or chartered flight operated by a scheduled airline whether as a passenger, pilot, operator or crew member.”

The contingent beneficiary claimed the AD&D benefits, which the administrator denied under the exclusion. She administratively appealed unsuccessfully, then sued the plan participant’s employer (IPG) and the insurer (NUFIC).

The Sixth Circuit affirmed dismissal of the claim against IPG (providing a misleading benefits guide which did not mention the exclusion; equitable reformation; and failing to providing a plan summary) because there was no allegation the plan participant read or misunderstood the benefits guide, or that IPG misled him in any way. Moreover, failing to provide a plan summary does not allow a substantive remedy of benefits.

As to the claims against NUFIC under §502(a)(3), there was no allegation “that NUFIC took any actions that could support a plausible breach of fiduciary [duty] claim” because there was no alleged misrepresentation by NUFIC, or facts to establish that the plan participant read the guide and decided not to obtain alternative coverage because of it.

The Court concluded the plaintiff was “not entitled to benefits under §502(a)(1)(B) or any form of equitable relief under §502(a)(3). ■

CIVIL NEW
RULES

DISCOVERY

Michigan’s new civil discovery rules
become effective **January 1, 2020.**

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